General

Guideline Title

Best evidence statement (BESt). Timing of patient/family preoperative education and its relationship to retention of information.

Bibliographic Source(s)

Cincinnati Children's Hospital Medical Center. Best evidence statement (BESt). Timing of patient/family preoperative education and its relationship to retention of information. Cincinnati (OH): Cincinnati Children's Hospital Medical Center; 2012 May 30. 5 p. [11 references]

Guideline Status

This is the current release of the guideline.

Recommendations

Major Recommendations

There is insufficient evidence and a lack of consensus to make a recommendation on the timing of preoperative education for children and adolescents.

Clinical Algorithm(s)

None provided

Scope

Disease/Condition(s)

Conditions requiring operative procedures

Guideline Category

Counseling

Management

Clinical Specialty

Family Practice

Pediatrics

Surgery

Intended Users

Advanced Practice Nurses

Nurses

Physician Assistants

Physicians

Social Workers

Guideline Objective(s)

To evaluate, among preoperative children and adolescents, if education regarding pre and postoperative surgical instructions provided during the preoperative visit for physical examination compared to preoperative education provided at the time of diagnostic visit increases patients'/parents retention of pre and postoperative surgical instructions

Target Population

Children and adolescents, age birth to 18 years, scheduled for a surgical procedure and their caregivers

Interventions and Practices Considered

Patient/family preoperative education

Major Outcomes Considered

Patients'/parents retention of pre and postoperative surgical instructions

Methodology

Methods Used to Collect/Select the Evidence

Searches of Electronic Databases

Description of Methods Used to Collect/Select the Evidence

Search Strategy

- An extensive search of the literature from: 1996 to February 2011
- Database: CINAHL, Medline, Google Scholar.
- Search terms: Preoperative period, preoperative education, preoperative care, patient education, knowledge retention, comprehension, surgery, pediatric.

Number of Source Documents

Not stated

Methods Used to Assess the Quality and Strength of the Evidence

Weighting According to a Rating Scheme (Scheme Given)

Rating Scheme for the Strength of the Evidence

Table of Evidence Levels

Quality Level	Definition
1a† or 1b†	Systematic review, meta-analysis, or meta-synthesis of multiple studies
2a or 2b	Best study design for domain
3a or 3b	Fair study design for domain
4a or 4b	Weak study design for domain
5a or 5b	Other: General review, expert opinion, case report, consensus report, or guideline

†a = good quality study; b = lesser quality study

Methods Used to Analyze the Evidence

Systematic Review

Description of the Methods Used to Analyze the Evidence

Not stated

Methods Used to Formulate the Recommendations

Expert Consensus

Description of Methods Used to Formulate the Recommendations

Not stated

Rating Scheme for the Strength of the Recommendations

Table of Recommendation Strength

Strength	Definition
"Strongly Recommended"	There is consensus that benefits clearly outweigh risks and burdens (or visa-versa for negative recommendations).
"Recommended"	There is consensus that benefits are closely balanced with risks and burdens.
No recommendation made	There is lack of consensus to direct development of a recommendation.

Note: See the original guideline document for the dimensions used for judging the strength of the recommendation.

Cost Analysis

A formal cost analysis was not performed and published cost analyses were not reviewed.

Method of Guideline Validation

Peer Review

Description of Method of Guideline Validation

This best evidence statement (BESt) was reviewed by two members of the Cincinnati Children's Medical Center Evidence Federation against established criteria.

Evidence Supporting the Recommendations

Type of Evidence Supporting the Recommendations

Individual studies, systematic reviews and expert opinions were examined that did show effectiveness of various preoperative teaching methods, but no studies were found that answered the population/problem, intervention, comparison, outcome (PICO) question directly regarding the optimal timing or setting of preoperative education to maximize knowledge retention.

Benefits/Harms of Implementing the Guideline Recommendations

Potential Benefits

Studies over the past thirty years have shown that preoperative preparation has the potential to impact a wide range of outcomes including increased knowledge of the procedure, decreased anxiety levels, compliance with prescribed activities, and establishing a trusting relationship between families and health care providers.

Potential Harms

- Some families have expressed concern that preoperative education may increase their child's anxiety. In certain situations this has been shown to be true. Children with prior experience, especially if the experience was perceived negatively, showed increased levels of anxiety compared to naïve children after viewing hospital relevant audiovisual materials. These children may do better when prepared with coping skills in addition to procedural information.
- Some parents and children cope by avoidance and may experience increased anxiety when health information is provided. Certain information may be necessary, but refocusing may be the most effective intervention for these individuals.

Qualifying Statements

Qualifying Statements

This Best Evidence Statement addresses only key points of care for the target population; it is not intended to be a comprehensive practice guideline. These recommendations result from review of literature and practices current at the time of their formulation. This Best Evidence Statement does not preclude using care modalities proven efficacious in studies published subsequent to the current revision of this document. This

document is not intended to impose standards of care preventing selective variances from the recommendations to meet the specific and unique requirements of individual patients. Adherence to this Statement is voluntary. The clinician in light of the individual circumstances presented by the patient must make the ultimate judgment regarding the priority of any specific procedure.

Implementation of the Guideline

Description of Implementation Strategy

An implementation strategy was not provided.

Institute of Medicine (IOM) National Healthcare Quality Report Categories

IOM Care Need

Getting Better

IOM Domain

Effectiveness

Patient-centeredness

Identifying Information and Availability

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Adaptation

Not applicable: The guideline was not adapted from another source.

Date Released

2012 May 30

Guideline Developer(s)

Cincinnati Children's Hospital Medical Center - Hospital/Medical Center

Source(s) of Funding

Cincinnati Children's Hospital Medical Center

Guideline Committee

Not stated

Composition of Group That Authored the Guideline

Group/Team Members: Katy Bolinger RN, BSN, CPN; Torica Fuller RNII, MSN, CGRN, CPN; Vickie Neyer RN, BSN, CPN, Care Manager; Lynda Nicholas RNII, BSN, CPN

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Financial Disclosures/Conflicts of Interest

No financial conflicts of interest were found.

Guideline Status

This is the current release of the guideline.

Guideline Availability

Electronic copies: Available from the Cincinnati Children's Hospital Medical Center Web site .

Print copies: For information regarding the full-text guideline, print copies, or evidence-based practice support services contact the Cincinnati Children's Hospital Medical Center Health James M. Anderson Center for Health Systems Excellence at EBDMInfo@cchmc.org.

Availability of Companion Documents

None available

Patient Resources

None available

NGC Status

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